

SENECA LAKE STATE PARK CRYPTOSPORIDIUM OUTBREAK

Marler Clark Questionnaire

The following questionnaire is designed to assist us in evaluating your claim. It is important that you read and answer each question carefully. The information you provide in this questionnaire may be given to the attorneys representing the defendant. Do not attempt to answer a question if you do not know the answer. Complete a separate questionnaire for each injured person.

INJURED PERSON

Name _____			
_____	_____	_____	_____
First	Middle	Last	
Address _____			
City _____		State _____	Zip _____ County _____
Birthdate ____/____/____		Age At Time of Injury _____	
Social Security Number _____			
<i>If injured person is less than 18 years</i>			
Parent/Guardian Name _____			
Address (if different from above) _____			
City _____		State _____	Zip _____
Contact information for injured person (or parent/guardian if injured is less than 18 years)			
Home Telephone (____) _____		Work Telephone (____) _____	
Mobile Telephone (____) _____		Email _____	
Name, Age and Illness Status of all persons residing in the same household as injured person			
Name	Age	Relationship to Injured Person	Ill (Yes/No)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Person Completing Questionnaire _____		Date Completed ____/____/____	

NOTE TO ADULTS: If you did not become ill but you are the spouse or parent(s) of a child who became ill, please also complete page 5, "Spousal and Parental Consortium Claims."

SENECA LAKE STATE PARK

In the **14** days before your/claimant's symptoms started, did you/claimant visit Seneca Lake State Park

yes no don't know

IF YES. For each visit during the 14 days before symptom onset, complete the following:

1. Date Visited: _____ Area visited Sprayland Playground swimming area

2. Date Visited: _____ Area visited Sprayland Playground swimming area

3. Date Visited: _____ Area visited Sprayland Playground swimming area

4. Date Visited: _____ Area visited Sprayland Playground swimming area

IF NO: Between June 1, 2005 and August 15, 2005 has a family member/close contact experienced symptoms similar to the symptoms you/claimant has experienced?

yes no don't know

IF YES, List the name(s) of that person and the relationship to you/claimant.

Was that person(s) diagnosed with cryptosporidium?

yes no don't know

OTHER EXPOSURES

There are many ways a person can become infected with Cryptosporidium. In order to evaluate all of the potential sources of your/claimant's illness, please answer the following questions using **up to 14 days** before symptoms started as the point of reference/

Date of symptom onset _____

Between that date and 14 days before symptoms started did you/claimant:

Attend day care yes no don't know

Wear diapers or have contact with someone in diapers yes no don't know

Consume raw fruits or vegetables yes no don't know

Visit a fair, zoo, or pet shop? yes no don't know

Live on a farm or have contact with farm animals? yes no don't know

Go camping? yes no don't know

Have exposure to other recreational water sources other recreational water other than at Seneca Lake? yes no don't know

What is your/claimant's primary source of drinking water?

municipal water system private water system private well

bottled water don't know

CLINICAL SIGNS AND SYMPTOMS

When did you/claimant first become ill? _____/_____/_____

Which, if any, of the following symptoms did you/claimant have?

- | | | | | |
|-----------------|------------------------------|-----------------------------|-------------------------------------|-----------------------------------|
| Nausea | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Vomiting | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | If YES, Date Start ____/____/____ |
| Diarrhea | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | If YES, Date Start ____/____/____ |
| Bloody Diarrhea | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | If YES, Date Start ____/____/____ |
| Stomach cramps | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Fever | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Chills | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Muscle aches | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Fatigue | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |
| Headache | <input type="checkbox"/> yes | <input type="checkbox"/> no | <input type="checkbox"/> don't know | |

Describe other signs or symptoms that you/claimant had.

HEALTH CARE PROVIDER CONTACT/HOSPITALIZATION

Did you/claimant see a doctor or require hospitalization as a result of this illness?

yes no

If YES, please specify providers/facilities and dates of treatments below: *(If you require additional space, you may continue on a separate sheet of paper.)*

1. Provider/Facility Name _____

Address _____

City _____ State _____ Zip _____

Telephone (____) _____

Dates of Treatment: From ____/____/____ to ____/____/____

2. Provider/Facility Name _____

Address _____

City _____ State _____ Zip _____

Telephone (____) _____

Dates of Treatment: From ____/____/____ to ____/____/____

LABORATORY TESTING FOR CRYPTOSPORIDIUM

Were any laboratory tests conducted to determine the cause of your/claimant's illness?

yes no don't know

IF YES

Name of Laboratory _____

Address _____

City _____ State _____ Zip _____

Were tests positive for Cryptosporidium? yes no don't know

Were test results reported to a health department? yes no don't know

If YES, which health department? _____

HEALTH DEPARTMENT/OTHER GOVERNMENT AGENCY CONTACT

Did you/claimant speak with anyone at a local, state, or federal health department or other agency about you/claimant's illness?

yes no don't know

If YES, which health department or agency

Name of health department contact: _____

INJURED PERSON'S PRESENT CONDITION

What is the present status of your/claimant's health

Describe any symptoms you/claimant are still experiencing

List any future appointments you/claimant may have related to this illness.

Doctor _____

Address _____

City _____ State _____ Zip _____

Telephone () _____ Date of Appointment ____/____/____

Purpose of Appointment _____

MEDICAL INSURANCE

Did you/claimant have any medical expenses for diagnosis, treatment, recovery, etc. that were related to your/claimant's illness? yes no don't know

IF YES,

Were any of the medical expenses that you/claimant had because of your illness paid for by any type of health insurance? yes no don't know

If YES,

Name of Health Insurance Plan: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone No.: _____

Subscriber name (if different from claimant) _____

Subscriber account number: _____

Adjuster/Employee Name _____

MISSED WORK DAYS

You/claimant may be eligible to be reimbursed for lost wages due to time missed at work as a result of the illness even if the missed time was covered by sick leave, vacation time, disability, etc.

Did you/claimant miss any time at work because of the illness? yes no don't know

IF YES:

Employer _____

Address _____

City _____ State _____ Zip _____

Telephone () _____

Nature of Work _____

HOURLY rate of pay \$ _____

(If a salaried employee, please estimate hourly rate.)

Estimated total amount of wage loss \$ _____
(Hourly rate X hours of work missed.)

SPOUSAL AND PARENTAL CONSORTIUM CLAIMS

If you are an adult who was not ill, but your spouse, child, or children were infected, you may be able to make a claim for the impact your family member's illness has had upon you.

Your name: _____

Relationship to ill person _____

What did you have to do differently while your child, children, or spouse were ill?

What impact has your child, children or spouse's illness had upon you?

Please use the space below to provide additional information that you feel will allow us to better evaluate your potential claim.